CENTRAL DISTRICT HEALTH DEPARTMENT

Check _____

Cash _____

CLIENT DATA FORM

How many hours did you fast? _____

Have we tested you before? **Y N**

SEX: √ ❒ Female ❒ Male **BIRTH DATE: _____/_____/_____**
month day year

NAME (Print) _____ _____
LAST name **FIRST name**

ADDRESS (number/street) _____

CITY _____ **STATE** _____ **ZIP**_____ **PHONE** _____

YOUR AGE _____ **YOUR HEIGHT**_____ **YOUR WEIGHT**_____

	Circle one
CURRENT HISTORY	
Are you currently under physicians care?	**Y N**
Are you currently using tobacco?	**Y N**
Do you currently do some form of physical activity on a regular basis? (at least 3 times/week)	**Y N**

DIABETES	
Does a parent, grandparent, brother, or sister have diabetes? **√ Check box if unknown ❒**	**Y N**
Do you have diabetes? If yes, do you control diabetes by:	**Y N**
Medicine: Y N Diet: Y N Exercise: Y N	

HEART HEALTH	
Do you take cholesterol-lowering medication?	**Y N**
Do you take blood pressure medication?	**Y N**

CONSENT FOR BLOOD SAMPLE:

I consent to having a blood sample drawn for the purpose to determine my blood cholesterol level. The screening will be kept confidential. **UNDER 18 a parent signature is required**

_____ _____ _____
Signature **Parent/Guardian** **Today's Date**

THIS FORM ALSO AVAILABLE ON CDHD WEB SITE:
www.cdhd.idaho.gov

5-2-05

_____/_____
BP Reading